Scottish Parliament Region: North East Scotland

Case 200602811: Tayside NHS Board

Summary of Investigation

Category

Health: clinical treatment/diagnosis

Overview

The complainant (Mrs C) said that the death of her husband (Mr C) could have been avoided if staff of Tayside NHS Board (the Board) had done more to establish the extent of his condition. Mrs C felt that the diagnostic process was unnecessarily delayed and that, had Mr C's liver cancer been diagnosed sooner, it may have been treatable.

Specific complaint and conclusion

The complaint which has been investigated is that the Board took unnecessarily long to diagnose and treat Mr C's condition (*not upheld*).

Redress and recommendation

The Ombudsman recommends that the Board consider ways to minimise any delays to cases being discussed by the upper gastrointestinal multi-disciplinary team.

The Board have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. The aggrieved (Mr C) had a history of liver disease and, as such, regularly attended a gastroenterology clinic at Ninewells Hospital. Upon one such attendance, in February 2006, a CT scan was carried out, the results of which prompted the gastroenterological team to request further specialist investigations.

2. Mr C's condition was investigated by the upper gastrointestinal multi-disciplinary team (the Upper GI Team) during April and May 2006. It was confirmed that Mr C had a cancerous tumour on his liver. A laparoscopy was carried out on 19 May 2006, the conclusion of which was that the tumour was too large to be operated on. Mr C died in early September 2006.

3. Through her MSP, Mr C's wife (Mrs C) complained to Tayside NHS Board (the Board) that, although concerns were raised over Mr C's condition by the gastroenterology team in February 2006, it was not until April 2006 that his cancer was diagnosed and, by that time, it was too late to operate on his tumour. Mrs C was dissatisfied with the Board's response to her complaint and brought the matter to this office in December 2006.

4. The complaint from Mrs C which I have investigated is that the Board took unnecessarily long to diagnose and treat Mr C's condition.

Investigation

5. In order to investigate this complaint, I have reviewed all of the complaint correspondence between Mrs C and the Board. I have also sought professional medical advice from our independent professional advisers (the Adviser) and reviewed the Board's clinical records for Mr C.

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The Board took unnecessarily long to diagnose and treat Mr C's condition

7. Mr C was diagnosed as having cirrhosis of the liver in November 2002. Management of this condition required him to attend follow-up out-patient

appointments with Ninewells Hospital's gastroenterology department. During these general gastroenterology clinics, routine tests would be carried out to monitor his condition and to screen for hepatoma.

8. The Adviser explained to me that hepatoma is a primary cancer of liver tissue which is rarely seen in the absence of cirrhosis. It is, therefore, considered to be a potential complication of liver cirrhosis. To screen for hepatoma, the level of alpha-fetoprotein (AFP) present in the blood is measured. Alpha-fetoprotein is a protein which is found in low concentrations in normal adult blood, but which is found in considerably increased concentration in the presence of hepatoma.

9. Mr C attended his general gastroenterology clinic on 6 February 2006. The clinical records for this consultation are brief, but note that he was 'ok' and looked 'well'. No significant symptoms or signs are recorded at this point to suggest that anything is wrong, however, a liver ultrasound and AFP measurement were arranged as routine follow-up investigations. This was confirmed in writing in a letter to Mr C's GP. Again, the records are limited and inconclusive, but the Adviser has presumed that the results of the ultrasound, which was carried out on 17 March 2006, gave rise to further investigation and a CT scan of Mr C's liver was organised. This assumption is supported by the correspondence between consultants arranging Mr C's ongoing care.

10. The CT scan was carried out on 22 March 2006. The results suggested that Mr C had a hepatoma and this was explained to him in a meeting with a consultant gastroenterologist on 10 April 2006. The note that followed this meeting stated that the consultant had checked Mr C's AFP levels and that he would arrange for his case to be discussed at the next Upper GI Team meeting a 'week Wednesday'.

11. Mr C's case was discussed, as planned, during the Upper GI Team meeting of 19 April 2006. It was decided that surgical treatment should be attempted and an appointment was arranged for Mr C to be seen by the hepatobiliary surgeons within two weeks. In the meantime, an MRI scan was performed on 3 May 2006. Although the result of this is not included in the clinical records, it was available to the surgeons at the time of their consultation with Mr C and showed a 'large, well encapsulated lesion in segment IVb' of the liver.

12. A laparoscopy was arranged for and carried out on 19 May 2006 to determine the extent of the tumour. The Adviser explained to me that surgery in a normal liver is technically very difficult but much more so in a cirrhotic liver, as the structure of the liver is disturbed and its function impaired. Although 75 percent of a healthy liver can be removed safely, removal of small sections of a cirrhotic liver can lead to liver failure, as it is already functioning at a compromised rate. The situation is complicated further by the fact that hepatomas can often develop in more than one part of the liver at the same time. Generally speaking, surgical removal of a hepatoma would only be attempted if there is one single tumour, less than 5 centimetre diameter, with no evidence of capsular or vascular invasion. In the UK, less than 30 percent of newly diagnosed hepatomas are deemed suitable for resection.

13. In Mr C's case, his tumour was measured at 6.6 centimetre diameter and was deemed inoperable. With no effective treatment available, Mr C continued to be seen by liver specialists who managed his symptoms until sadly, he died on 5 September 2006.

Conclusion

14. Rather than presenting as the development of new symptoms, Mr C's hepatoma was discovered as the result of routine investigations during the course of out-patient follow-up for his cirrhosis. The timing of his diagnosis was, therefore, somewhat dependent on the dates of his general gastroenterology clinics.

15. In the absence of any indicating symptoms, there was no urgency in arranging an ultrasound following the clinic of 6 February 2006. The delay of approximately six weeks between requesting the ultrasound and it being carried out, whilst undesirable, was reasonable given the non-urgent nature of the scan. Although the corresponding clinical records are scant, it would appear that the ultrasound provided some cause for concern, and a CT scan was quickly carried out five days later without a further out-patient appointment being required.

16. Mr C was given his results around three weeks after his CT scan was carried out. The outcome of this consultation, on Tuesday 10 April 2006, was that his case was referred for discussion at the Upper GI Team meeting of Wednesday 19 April 2006. The Upper GI Team at Ninewells Hospital meet every Wednesday to discuss new and pre-existing cases. I consider it to be

reasonable that Mr C's case should be reviewed at the meeting of 19 April 2006 rather than the day immediately following his consultation of the 10 April 2006.

17. Between the CT scan and Mr C's case being considered by the Upper GI Team, there was a delay of four weeks, which I consider excessive given the results of the scan. The bulk of this delay resulted from the results being discussed at Mr C's next scheduled general gastrointestinal clinic which was three weeks after his scan.

18. Once the Upper GI Team became involved in Mr C's case, the action taken was rapid and well organised.

19. Mrs C complained that Mr C's death could have been avoided had his condition been diagnosed and treated more quickly. In her complaint to the Board she noted that Mr C first had a scan on 6 February 2006 but it wasn't until 19 May 2006 that any form of operation was attempted. It is clear from the clinical records that Mr C had no symptoms to suggest that he had a cancerous tumour. It was not until the routine ultrasound of 17 March 2006 that any suspicions arose. Following the ultrasound, I have identified one delay significant enough to cause concern over the urgency of Mr C's treatment.

20. I asked the Adviser whether the four week delay between Mr C's CT scan and his case being discussed by the Upper GI Team could have contributed to his tumour being too large to be removed. He advised me that the severity of M C's condition and the size of his tumour was such that his hepatoma would have to have been identified much earlier for the outcome to have been any different. Whilst there was some delay to his eventual laparoscopy, this would not have had any significant impact on Mr C's condition, as his tumour would already have developed too far by the time it was identified in March 2006. As the lack of any identifying symptoms prevented medical staff from diagnosing Mr C's tumour any earlier than they did, I do not uphold this complaint.

Recommendation

21. Although I did not uphold this complaint, I was concerned at the length of time taken to provide Mr C with his CT scan results, which indicated the severity of his condition. These were provided at his next scheduled consultation, three weeks after the scan, resulting in a significant delay in his case being reviewed by the Upper GI Team. I would consider it good practice to communicate significant scan results at the earliest convenience so that arrangements can be

made for cases to be discussed by the Upper GI Team with as little delay as possible.

22. The Ombudsman, therefore, recommends that the Board consider ways to minimise any delays to cases being discussed by the Upper GI Team.

23. The Board have accepted the recommendation and will act on it accordingly. The Ombudsman asks that the Board notify her when the recommendation has been implemented.

Annex 1

Explanation of abbreviations used

Mr C	The aggrieved, Mrs C's husband
The Upper GI Team	The upper gastrointestinal multi-disciplinary team
Mrs C	The complainant
The Board	Tayside NHS Board
The Adviser	An independent professional medical advisor
AFP	Alpha-fetoproteins